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2016 075240

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2016 NOV -8 AM 8:58

MICHAEL B. BROWN
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Dana R. Gallagher, being first duly sworn upon her oath, deposes and says as follows:

1. That she currently resides at 2554 37th Street, Apt. 4, Astoria NY 11103

2. That affiant is the daughter of David Brian Gallagher, who died testate a resident of Lake County, Indiana on the 21st day of September, 2016, and whose record of death is duly entered in the records maintained by the Lake County Health Department, Crown Point, Lake County, Indiana.

3. That decedent acquired real estate with Sandra J, Gallagher as Husband and Wife, and they remained Husband and Wife at the time of her death, on the 18th day of December, 1991, in Lake County, Indiana,

said real estate being commonly known as 1121 East Hickey Street, Hobart, Indiana, and legally described as follows:

> Lot Number 2 in Van Black's Addition to the City of Hobart, as per plat thereof recorded in Plat Book 23, page 36 in the Office of the Recorder of Lake County, Indiana.

Parcel No.: 45-09-29-453-016.000-018

4. That no estate was opened at the time of death of Sandra J. Gallagher, and no estate or inheritance tax is due as a result of her death.

5. That this Affidavit is made for the purpose of establishing the above facts, and for inducing the Meridian Title Corporation to rely hereon and in reliance hereon to issue a policy of title insurance free of any objection based upon the death of Sandra J. Gallagher, deceased.

Further Affiant sayeth not.

IN WITNESS WHEREOF, the said Dana R. Gallagher has hereunto set her hand and seal this 20 day of October, 2016.

Dana R. Gallagher

FILED

$15.00

OCT 31 2016 6331

JOHN E. PETALAS
LAKE COUNTY AUDITOR

MT

FOR MERIDIAN TITLE CORP

16-32941

STATE OF NEW YORK)
)SS:
COUNTY OF NEW YORK)

Subscribed and sworn to before me a Notary Public in and for said County and State, this 20th day of October, 2016.

Jillian H. Martinez
Notary Public

JILLIAN HELEN MARTINEZ
Notary Public - State of New York
NO. 01MA6253940
Qualified in New York County
My Commission Expires Jan 9, 2020

Resident of NY County
My Commission Expires: 1/9/20

6 CC's

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

cal No. 3182-91 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): SANDRA J. GALLAGHER
2. SEX: FEMALE
3a. TIME OF DEATH: 12:54 AM
3b. DATE OF DEATH (Month, Day, Yr.): DECEMBER 18, 1991
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 49
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): SEPT. 6, 1942
7. BIRTHPLACE (City and State or Foreign Country): MENOMONIE, WISCONSIN
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: NONE
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 1121 HICKEY STREET
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): DAVID B. GALLAGHER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): LAB TECHNICIAN
12b. KIND OF BUSINESS/INDUSTRY: ST. MARY MEDICAL CENTER
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 1121 HICKEY STREET
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): LEONARD H. MAVES
19. MOTHER'S NAME (First, Middle, Maiden Surname): ELINOR A. HEGEMAN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DAVID B. GALLAGHER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1121 HICKEY STREET, HOBART, IN. 46342
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 20, 1991 CALUMET PARK CEMETERY
21c. LOCATION—City or Town, State: MERRILLVILLE, INDIANA
22a. EMBALMER'S NAME: GORDON L. JONES
22b. EMBALMER'S LICENSE NO.: 1010711
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b. LICENSE NUMBER (of Licensee): 1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH# 83002380 701 E. 7th STREET, HOBART, IN. 46342

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. GLIOBLASTOMA MULTIFORME — Approximate Interval Between Onset and Death: 1 YR
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

DEC 19 1991

Alexander D. Williams, MD

LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO.: 01030107
29d. DATE SIGNED (Month, Day, Year): 12-18-91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): BHARAT H. BARAI, M. D., 125 E. 89th AVENUE, MERRILLVILLE, IN. 46410 (736-2800)

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams, MD
32. DATE FILED (Month, Day, Year): December 19, 1991

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED:
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.